STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155218	B. WIN			03/29/20	011
NAME OF I	DOWNER OF CURRINE		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
NAME OF F	PROVIDER OR SUPPLIER			2300 G	REAT LAKES DRIVE		
	CY PLACE OF DYE			, i	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	IAU)	<u> </u>	DATE
F0000	This visit was for	r a Post Survey Revisit	F00	00	The facility requests that this		
	(PSR) to the the	Investigation of			plan of correction be considered	ed	
	Complaint IN00085845 completed on 3/3/11				its credible allegations of		
					compliance.		
	This visit was in	conjunction with a Post			Submission of this response ar		
	Survey Revisit (PSR) to to the PSR				Plan of Correction is not a lega		
	`	plaint IN00083771			admission that a deficiency ex	ısts	
	investigated on 1				or that this statement of		
	investigated on i	2/20/10.			deficiency was correctly cited		
	Complaint INO00	085845 not corrected.			and is also not to be construed		
	Complaint involv	083843 flot corrected.			an admission of interest against the facility, the Administrator,		
	C	I			any employee, agents, or other		
	Survey dates: M	farch 28 and 29, 2011			individuals who draft or may b		
		222422			discussed in the response and		
	Facility number:				Plan of Correction. In addition	n	
	Provider number				preparation and submission of		
	AIM number: 10	00266720			Plan of Correction does not		
					constitute an admission or		
	Survey team:				agreement of any kind by the		
	Janelyn Kulik, R	N, TC			facility of the truth of any fact	s	
	Regina Sanders,	RN			alleged or the corrections of a		
	Sheila Sizemore,	, RN			conclusions set forth in this		
	(March 28, 2011)			allegation by the survey agenc	y.	
	Marcia Mital, RN	N					
	(March 28, 2011)			Accordingly, the facility has		
	Kelly Sizemore,	'			prepared and submitted this Pl	an	
	(March 28, 2011				of Correction prior to the		
		•			resolution of appeal of this ma	tter	
	Census bed type:				solely because of the		
	SNF/NF: 153	-			requirements under State and		
	Total: 153				Federal law that mandates		
	10tai. 133				submission of the Plan of Corrections a condition to		
	Cancus nover to	na:			participate in the Title 18 and		
	Census payor typ	<i>.</i>			participate in the Thie 16 and		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000123

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155218	A. BUILDING		03/29/2011
		100210	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF F	PROVIDER OR SUPPLIER			REAT LAKES DRIVE	
	CY PLACE OF DYE		DYER,	IN46311	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	Medicare: 36	,		Title 19 programs. The	
	Medicaid: 93			submission of Plan of Correct	ion
	Other: 24			within this timeframe should i	l l
	Total: 153			no way be of non-compliance	or
				admission by the facility.	
	Sample: 11				
	These deficiencie	es also reflect State			
	findings in accor	dance with 410 IAC 16.2.			
	Quality review co	ompleted 4-4-11			
	Cathy Emswiller				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/29/2011		
	PROVIDER OR SUPPLIER			2300 G	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE IN46311		
(X4) ID PREFIX TAG F0224 SS=D	Based on observate record review, the a resident's care with the leaving a resident bowel movement time, for 1 of 10	ratement of Deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ation, interview, and e facility failed to ensure was not neglected related ent lying in incontinent at for a long period of residents who require bileting in a sample of 11.	F02	ID PREFIX TAG 24	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) It is the practice of this facility ensure the highest quality of cris afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was:	to are he	(X5) COMPLETION DATE 04/11/2011
	"Abuse", receive Administrator, in "neglectstrict specific resident card that identify reduce the risk of neglected" A facility policy, Federal Abuse, N	dated 10/09, titled, d as current from the			Peri care was provided to the R. E. Resident was interviewed an stated she waited approximately hour for staff to provide care. Staff involved have been counse and educated on promptly responding to resident needs. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Interviewable residents were asked if they had any issues related to timeliness of care and round.	dd y 1 eled r	
	Administrator, in Failure to provid necessary to avoid anguish, or mental During an intervia.m., Resident #F waiting an hour to	dicated, "Neglect, e goods and services d physical harm, mental al illness" Lew on 03/28/11 at 11:42 E indicated she had been			on non-interviewable residents were also made. No other issues were identified through this process. The measures put into place as systemic change made to ensu the deficient practice does not recur is:	nd re	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155218	B. WIN			03/29/2011
			1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2300 G	REAT LAKES DRIVE	
REGENO	CY PLACE OF DYE	२		1	IN46311	_
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		r call light and she told				
	the CNA she had	been incontinent. She			Care staff has been educated by	
	indicated CNA#	1 turned off the call light			the DNS and ED related to time	-
	and told her she	was busy with another			call light response and provision care at the time of need. Rando	
		ther CNA had been			call light audits are conducted b	I
		esident. She indicated			department managers to ensure	- 1
	~	e Nurse. Resident #E			timely response. Department	
		3 came into the room and			managers are conducting daily	
					interview with residents to ensu	re
		LPN she had been			resident needs are being met.	
		wel movement and the				
	LPN told her she	would tell the CNA			To ensure the deficient practice	
	assigned to her.				does not recur, the monitoring	
					system established is:	
	During an intervi	iew on 03/28/11 at 11:45				
	_	licated the resident had			A Performance Improvemen	
	l '	been incontinent of bowel			tool has been developed that	
		#3 indicated she had not			evaluates timely provision of	`
		sident's CNA because the			care. DNS or Designee will	
					complete PI tool weekly for	
		ak. She indicated she			four weeks, monthly for a	
	would go tell the	CNA now.			quarter and quarterly	
					thereafter with results being	
	During an intervi	iew on 03/28/11 at 11:50			forwarded to the PI committ	
	a.m., CNA #2 inc	dicated she was assigned			for further review until 100%	⁄o
	to Resident #E.	She indicated she had			compliance is achieved.	
	returned from a 3	30 minute lunch break at				
	11:20 a.m. She i	ndicated she was just				
		dent needed some help.				
		and the second second merp.				
	During an observ	vation on 03/28/11 at				
	~					
	l '	#2 entered Resident #E's				
	_	incontinence care to the				
		sident was observed to				
	have been incont	inent of soft bowel				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/29/2011		
	PROVIDER OR SUPPLIER		p. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE N46311	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	dried on the residinterviewing the observation, she bowel movement resident's skin. Our area several time bowel movement was red and excessuperficial open at thigh which was a dime, round in around the open interview at the true CNA #2 indicate excoriated on the She indicated that thigh was opened. During an interview incontinence care Resident indicated laying in the bowell During an interview in the bowell D	new on 03/28/11 after the e had been completed, the ed she was uncomfortable					

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		STREET A 2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	Е		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	p.m., CNA #1 in told her she had movement. She is ready to give and but answered Re indicated she had and left the room resident had been help. She indicated what time she and light. Resident #E's ready 12:10 diagnoses include to, hypertension The Resident's POrders, dated 03 Resident was cap health decisions. The Annual Min Assessment, date resident was cog score of 15, required for toileting, bed hygiene, and was of bowel (two or	imum Data Set ed 01/18/11, indicated the nitively intact with a ired extensive assistance mobility, and personal as frequently incontinent					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING		COMPLETED 03/29/2011			
		100210	B. WI		DDDEGG CITY GTATE ZID CODE	1 00/20/2	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE		
	CY PLACE OF DYEF			DYER, I			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Sheet", 03/15/11	, indicated the resident					
	had no new skin	conditions.					
	The Resident's, "Skin Condition Rindicated the resithe bilateral thigh on 03/17/11. The Nurses' Note a.m. through 03/2 documentation to a red and excorian During an intervipum., LPN #3 inconstruction of the Nurses' Notes. This deficiency we Facility failed to plan of correction	Weekly Non-pressure Report", dated 03/17/11, ident had a fungal rash to as, which was resolved es, dated 03/13/11 at 8 25/11 12 a.m., lacked o indicate the resident had ated buttocks.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING	UNSTRUCTION		LETED
		STREET 2300 G	GREAT LAKES DRIVE	1	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	OF CORRECTION ROVIDER OR SUPPLIER SY PLACE OF DYEF SUMMARY S (EACH DEFICIENT	OF CORRECTION IDENTIFICATION NUMBER:	TOF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING STREET 2300 G CY PLACE OF DYER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET 2300 G DYER,	DEF CORRECTION IDENTIFICATION NUMBER: 155218 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVI	OF CORRECTION IDENTIFICATION NUMBER: 155218 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL OF COMPT A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/29/2011		
	PROVIDER OR SUPPLIER			2300 G	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE IN46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F0224 SS=D			F02	24	It is the practice of this facility ensure the highest quality of c is afforded our residents. Consistent with this practice, to following has been done: The corrective action taken for the residents found to have be affected by the deficient practive was: Peri care was provided to the R. E. Resident was interviewed an stated she waited approximately hour for staff to provide care. Staff involved have been counse and educated on promptly responding to resident needs. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Interviewable residents were asked if they had any issues related to timeliness of care and round on non-interviewable residents were also made. No other issue were identified through this process. The measures put into place as systemic change made to ensurthed deficient practice does not recur is:	are the ren ice es. d y 1 eled r	04/11/2011

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING			UNSTRUCTION	COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		STREET 2 2300 G	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE IN46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				Care staff has been educated the DNS and ED related to time call light response and provision care at the time of need. Rand call light audits are conducted department managers to ensure timely response. Department managers are conducting daily interview with residents to ensure sident needs are being met. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that evaluates timely provision of care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI commit for further review until 100 compliance is achieved.	nely on of lom by re rure g nt t of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/29/2011		
	ROVIDER OR SUPPLIER			2300 GI	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) It is the practice of this facility		(X5) COMPLETION DATE 04/11/2011
F0226 SS=D			F0226		It is the practice of this facility ensure the highest quality of c is afforded our residents. Consistent with this practice, t following has been done: The corrective action taken for the residents found to have be affected by the deficient practic was: Peri care was provided to the R. E. Resident was interviewed an stated she waited approximately hour for staff to provide care. Staff involved have been counse and educated on promptly responding to resident needs. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Interviewable residents were asked if they had any issues relate to timeliness of care and round on non-interviewable residents were also made. No other issues were identified through this process. The measures put into place an systemic change made to ensurthe deficient practice does not recur is:	are the ren ice es. d y 1 eled r	04/11/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/29/2011			
NAME OF P	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE	•	
REGENC	Y PLACE OF DYE	₹	DYER, IN46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
				Care staff has been educated the DNS and ED related to tin call light response and provisi care at the time of need. Rancall light audits are conducted department managers to ensu timely response. Department managers are conducting dail interview with residents to ensure the deficient practidoes not recur, the monitorin system established is: A Performance Improvement tool has been developed the evaluates timely provision care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI commit for further review until 100 compliance is achieved.	nely on of dom l by re y sure ce ng ent at of l	
			1	1		

	T OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION	COMPLETED
		155218	B. WING		03/29/2011
	PROVIDER OR SUPPLIER		2300 (ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE , IN46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	REGULATORY OR	LSC IDENTIFYING INFORMATION)	F0226	It is the practice of this facility ensure the highest quality of c is afforded our residents. Consistent with this practice, to following has been done: The corrective action taken for the residents found to have be affected by the deficient practice was: Peri care was provided to the R.E. Resident was interviewed and stated she waited approximately hour for staff to provide care. Staff involved have been counsed and educated on promptly responding to resident needs. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Interviewable residents were asked if they had any issues related to timeliness of care and round on non-interviewable residents were also made. No other issues were identified through this process. The measures put into place and systemic change made to ensurthe deficient practice does not the deficient practice does not	of to are 04/11/2011 are the office of the office o
				recur is:	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU		(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE GREAT LAKES DRIVE IN46311	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
				Care staff has been educated the DNS and ED related to the DNS and ED related to the call light response and provision care at the time of need. Rancall light audits are conducted department managers to ensure timely response. Department managers are conducting dail interview with residents to entersident needs are being met. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed the evaluates timely provision care. DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI commit for further review until 100 compliance is achieved.	nely on of dom l by re y sure ce ng ent at of l	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155218	B. WIN			03/29/2011	1
NAME OF F	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE	-	
DECENC)			l	REAT LAKES DRIVE		
	Y PLACE OF DYE	₹		DYER,	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re C	OMPLETION DATE
		·	F02		It is the practice of this facility	, to 0	
F0226		ation, record review and	F02	26	ensure the highest quality of ca		4/11/2011
SS=D		cility failed to ensure			is afforded our residents.		
	•	y was followed as			Consistent with this practice, t	he	
		leaving a resident lying			following has been done:		
		wel movement for a long					
	•	or 1 of 10 residents who			The corrective action taken for		
	•	e with toileting in a			the residents found to have been	en	
	sample of 11. (Ro	esident #E)			affected by the deficient practi	ce	
	Findings include: A facility policy, dated 10/09, titled,				was:		
					n		
					Peri care was provided to the Ro E. Resident was interviewed an		
					stated she waited approximately		
	•	d as current from the			hour for staff to provide care.		
	Administrator, in				Staff involved have been counse	led	
	_	ly prohibitedDevelop a			and educated on promptly		
	-	care plan and/or care			responding to resident needs.		
	-	resident care needs to			The corrective action taken for		
		f being abused and			those residents having the		
	neglected"				potential to be affected by the		
					same deficient practice is:		
		dated 10/08, titled,			-		
	Federal Abuse, N	leglect and Exploitation			Interviewable residents were		
	Definitions", rece	eived as current from the			asked if they had any issues rela		
	Administrator, in	dicated, "Neglect,			to timeliness of care and round on non-interviewable residents	lS	
	Failure to provid	e goods and services			were also made. No other issues	,	
	necessary to avoi	d physical harm, mental			were identified through this		
	anguish, or ment	al illness"			process.		
	During an intervi	iew on 03/28/11 at 11:42					
	a.m., Resident #I	E indicated she had been			The measures put into place ar	,d	
	waiting an hour t	o have her brief			systemic change made to ensu		
changed. She indicate		dicated CNA #1 came in			the deficient practice does not		
	and answered her	r call light and she told			recur is:		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155218	A. BUII B. WIN			03/29/2011	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	REAT LAKES DRIVE		
	CY PLACE OF DYER		DYER, IN46311				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
IAG			+	IAU	221 Telaker)	DATE	
		been incontinent. She			Care staff has been educated by	v.	
		1 turned off the call light			the DNS and ED related to time		
		was busy with another			call light response and provision	-	
		her CNA had been			care at the time of need. Rando		
	_	esident. She indicated			call light audits are conducted b	-	
		e Nurse. Resident #E			department managers to ensure		
		3 came into the room and			timely response. Department managers are conducting daily		
		LPN she had been			interview with residents to ensu	re	
	incontinent of bo	wel movement and the			resident needs are being met.		
	LPN told her she	would tell the CNA					
	assigned to her.				To ensure the deficient practice		
					does not recur, the monitoring		
	During an intervi	iew on 03/28/11 at 11:45			system established is:		
	a.m., LPN #3 ind	licated the resident had					
	told her she had l	been incontinent of bowel			A Performance Improvemen	l l	
	movement. LPN	#3 indicated she had not			tool has been developed that	l l	
		sident's CNA because the			evaluates timely provision of		
		ak. She indicated she			care. DNS or Designee will		
	would go tell the				complete PI tool weekly for		
	would go tell the	Civiliow.			four weeks, monthly for a quarter and quarterly		
	During an intervi	iew on 03/28/11 at 11:50			thereafter with results being		
	_	dicated she was assigned			forwarded to the PI committ	ee	
		She indicated she had			for further review until 100%		
		30 minute lunch break at			compliance is achieved.		
					r r		
		ndicated she was just					
	informed the resi	dent needed some help.					
	Daning a viv						
	_	vation on 03/28/11 at					
		#2 entered Resident #E's					
	•	incontinence care to the					
		sident was observed to					
		inent of soft bowel					
	movement. The	bowel movement had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/29/2011		
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311		
	SUMMARY S (EACH DEFICIEN REGULATORY OR dried on the resid interviewing the observation, she bowel movement resident's skin. Of area several time bowel movement was red and exces superficial open thigh which was a dime, round in around the open interview at the t CNA #2 indicate excoriated on the She indicated the thigh was opened During an intervient incontinence care Resident indicate laying in the bow During an intervient p.m., LPN #3 incontinence a.m. She indicate the unit were all phone with a fam	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Ident's buttocks. Upon CNA #2 during the indicated part of the thad dried on the CNA #2 then washed the s to remove the dried the The resident's buttocks oriated and there was a area on the posterior left approximately the size of shape and the skin area was pink. During an ime of the observation, define the skin was red and the Resident's buttocks. The resident's buttocks oriated and there was a first approximately the size of shape and the skin the skin was red and the skin was red and the Resident's buttocks. The resident's buttocks area on the left posterior the skin was red and the skin	P			TE	(X5) COMPLETION DATE

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
		155218	A. BUI B. WIN	LDING G		03/29/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	REAT LAKES DRIVE		
	CY PLACE OF DYE			<u>l</u>	IN46311		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	During an intervi	iew on 03/28/11 at 12:15					
	p.m., CNA #1 in	dicated the resident had					
		been incontinent of bowel					
		ndicated she was getting					
	•	other resident a shower,					
		sident #E's call light. She I turned the call light off					
		and told the nurse the					
		n incontinent and needed					
		ted she did not remember					
	what time she an	swered the resident's call					
	light.						
		cord was reviewed on					
		p.m. The Resident's					
	_	ed, but were not limited					
	to, hypertension	and osteoarthritis.					
	The Resident's P	hysician's Recapitulation					
		/11, indicated the					
	Resident was cap	oable of making her own					
	health decisions.						
	The Annual Mini						
	· ·	ed 01/18/11, indicated the					
	_	nitively intact with a ired extensive assistance					
		mobility, and personal					
	· ·	s frequently incontinent					
	of bowel (two or						
		t, "Weekly Skin Check					
	Sheet", 03/15/11	, indicated the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
TAG	had no new skin The Resident's, ' Skin Condition I indicated the res the bilateral thig on 03/17/11. The Nurses' Note a.m. through 03/documentation to a red and excoria During an interv p.m., LPN #3 in skin concerns, it the Nurses' Note This deficiency of Facility failed to plan of correction	Conditions. Weekly Non-pressure Report", dated 03/17/11, ident had a fungal rash to hs, which was resolved es, dated 03/13/11 at 8 25/11 12 a.m., lacked o indicate the resident had ated buttocks. iew on 03/28/11 at 1:05 dicated if the resident had would be documented in	TAG	DEFICIENCY	O NAIL	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/29/2011	
		100210	B. WIN		ADDRESS STEV STATE STE CODE	00/20/2	
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y PLACE OF DYE	₹	2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282			F02	82	It is the practice of this facility		04/11/2011
SS=D	Based on observa	ation, record review, and			ensure the highest quality of ca	are	
	interview, the fac	cility failed to ensure			is afforded our residents.	.	
	physician's order	s and resident's plans of			Consistent with this practice, the	he	
	care were follow	ed, related to			following has been done:		
	incontinence pro	ducts, incontinence care,			Th		
	_	catheter care for 2 of 11			The corrective action taken for		
	residents reviewe				the residents found to have bee		
		s and plans of care in a			affected by the deficient practi	ce	
		•			was:		
	sample of 11. (Residents #E and #F)				Res. E has been provided with		
					cloth briefs. Res. F's Ferrouse		
Findings include:				Sulfate was restarted on 3/28/11			
					Peri care was provided to Res. F		
	1. Resident #E's	record was reviewed on			Resident was interviewed and		
	03/28/11 at 12:10	p.m. The Resident's			stated she waited approximately	1	
	diagnoses includ	ed, but were not limited			hour for staff to provide care.		
	to, hypertension	and osteoarthritis.			Staff involved have been counse	led	
					and educated on promptly responding to resident needs.		
	A) A care plan, d	ated 03/24/11, indicated			responding to resident needs.		
		at risk for impaired skin			The corrective action taken for	.	
		proaches indicated, "1.	1		those residents having the		
	Keep skin clean	•			potential to be affected by the		
	recep skiii cicaii (ce (unu) ury			same deficient practice is:		
	During an interes	iew on 03/28/11 at 11:42			Residents with an order for clot	h	
	· ·				briefs have been observed to		
		E indicated she had been			ensure they are using cloth brief	is.	
	waiting an hour t				Full facility review of all		
	_	dicated CNA #1 came in			Medication Records was		
		r call light and she told			completed to ensure that there were no other transcription		
		been incontinent. She			errors. Interviewable residents		
		1 turned off the call light			were asked if they had any issue		
		was busy with another			related to timeliness of care and		
	resident and anot	her CNA had been			rounds on non-interviewable		
	assigned to the R	esident. She indicated			residents were also made. No		
					other issues were identified		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155218	B. WIN			03/29/2011	
NAME OF I	DROVIDED OD SLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2300 G	REAT LAKES DRIVE		
	CY PLACE OF DYE			<u>.</u>	IN46311		
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG			DATE	
		e Nurse. Resident #E			through this process.		
	indicated LPN #3 came into the room and						
		LPN she had been			The measures put into place and	nd	
		wel movement and the			systemic change made to ensu		
	LPN told her she	would tell the CNA			the deficient practice does not		
	assigned to her.				recur is:		
	During an intervi	iew on 03/28/11 at 11:45			 Nursing staff was educated		
	a.m., LPN #3 indicated the resident had told her she had been incontinent of bowel				the DNS on using cloth briefs	· 1	
					when ordered and following	'	
movement. LPN #3 indicated she had not				the plan of care. Licensed st	aff		
	informed the Resident's CNA because the CNA was on break. She indicated she				have been educated by the		
					DNS on correctly transcribing	ıσ	
					orders to the resident	·s	
	would go tell the	CNA now.			medication administration		
		00/00/44			record. Nursing staff has be	en	
	"	iew on 03/28/11 at 11:50			educated by the DNS and ED		
	· ·	dicated she was assigned			related to timely call light		
		She indicated she had			response and provision of car	re	
		30 minute lunch break at			at the time of need.		
	11:20 a.m. She i	ndicated she was just					
	informed the resi	dent needed some help.			To ensure the deficient practic		
					does not recur, the monitoring		
	During an observ	vation on 03/28/11 at			system established is:		
	11:53 a.m., CNA	#2 entered Resident #E's					
	l '	incontinence care to the			A Performance Improvemen		
	1 *	esident was observed to			tool has been developed that		
		inent of soft bowel			will monitor residents for the		
		bowel movement had			proper use of cloth briefs		
		lent's buttocks. Upon			according to the plan of care	·	
	interview of CNA	•			An additional Performance		
		indicated part of the			Improvement indicator has		
		t had dried on the			been established which		
					evaluates compliance with	6	
	resident's skin. (CNA #2 then washed the			transcribing physician order	5	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO			ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED
		155218	B. WIN	G		03/29/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TVIVIL OF I	NO VIDER OR SOLI EIEN			1	REAT LAKES DRIVE	
REGENO	CY PLACE OF DYE	R		DYER,	IN46311	
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	area several time	es to remove the dried			to the resident medication	
	bowel movemen	t. The resident's buttocks			administration record. The	
	was red and exco	oriated and there was a			DNS or Designee will comple	
	superficial open	area on the posterior left			PI tools weekly for four weel	KS,
	1 -	ximately the size of a			monthly for a quarter and	
	1	hape and the skin around			quarterly thereafter with	
	I	s pink. During an			results being forwarded to th	ne
	1 ^	time of the observation,			PI committee for further	
		d the skin was red and			review until 100% complian	ce
					is achieved. A Performance	
	excoriated on the Resident's buttocks. She indicated the area on the left posterior thigh was opened.				Improvement tool has been	
					developed that evaluates tim	ely
					provision of care. DNS or	
					Designee will complete PI to	l l
	During an interv	iew on 03/28/11 at 12:05			weekly for four weeks, mont	hly
	p.m., LPN #3 inc	dicated the Resident had			for a quarter and quarterly	
	told her about be	ing incontinent of bowel			thereafter with results being	
		d 11:20 a.m. or 11:30			forwarded to the PI committ	
		ed the other CNA's on			for further review until 100%	6
		busy and she was on the			compliance is achieved.	
		nily member so she could				
	1 *	•				
		resident when she				
	requested help.					
	D	. 02/20/11 + 12.15				
	ı	iew on 03/28/11 at 12:15				
	1 * ′	dicated the resident had				
		been incontinent of bowel				
	movement. She i	ndicated she was getting				
	ready to give and	other resident a shower,				
	but answered Re	sident #E's call light. She				
		d turned the call light off				
		and told the nurse the				
		n incontinent and needed				
		ted she did not remember				
	neip. She malca	ica she ara not femember				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP: 03/29/2	LETED	
	PROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	what time she an light.	swered the resident's call				
	•	t's Physician's orders, dated 03/11, er for cloth briefs.				
	11:53 a.m., CNA incontinence care CNA removed a brief and replace disposable, non-output During an interv	e on the resident. The disposable, non-cloth d the brief with a cloth brief. iew on 03/28/11 at 1:15 dicated the resident did				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		155218	B. WING		03/29/2011		
				ET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	2	2300 GREAT LAKES DRIVE				
REGENO	CY PLACE OF DYE	R		R, IN46311			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	_	5.112		
F0282			F0282	It is the practice of this facility			
SS=D				ensure the highest quality of c	are		
00 B				is afforded our residents.			
				Consistent with this practice,	the		
				following has been done:			
				The corrective action taken fo	r		
				the residents found to have be			
				affected by the deficient pract			
				was:			
				, , 			
				Res. E has been provided with			
				cloth briefs. Res. F's Ferrouse	,		
				Sulfate was restarted on 3/28/11	1.		
				Peri care was provided to Res.	E.		
				Resident was interviewed and			
				stated she waited approximately	y 1		
				hour for staff to provide care.			
				Staff involved have been counse	eled		
				and educated on promptly			
				responding to resident needs.			
				The corrective action taken fo	r		
				those residents having the			
				potential to be affected by the			
				same deficient practice is:			
				Residents with an order for clot	th		
				briefs have been observed to			
				ensure they are using cloth brie	fs.		
				Full facility review of all			
				Medication Records was			
				completed to ensure that there			
				were no other transcription			
				errors. Interviewable residents			
				were asked if they had any issue	I		
				related to timeliness of care and	l		
				rounds on non-interviewable			
				residents were also made. No			
				other issues were identified			
			•				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING	COMPLETED 03/29/2011		
		133210	B. WING		03/29/2011
NAME OF F	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	
REGENO	Y PLACE OF DYE	₹	I	REAT LAKES DRIVE IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFTING INFORMATION)	IAG	through this process.	DATE
				through this process.	
				The measures put into place a systemic change made to ens the deficient practice does no recur is: Nursing staff was educated the DNS on using cloth bries when ordered and following the plan of care. Licensed shave been educated by the DNS on correctly transcribin orders to the resident medication administration record. Nursing staff has be educated by the DNS and E related to timely call light response and provision of cat the time of need. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of car An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician order.	by fs g taff ing een D are ce g nt t t ee

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/29/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	RESOLATORY OK	LOC BEATH THO BY ORWATION)	IAU	to the resident medication administration record. The DNS or Designee will comple PI tools weekly for four wee monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliant is achieved. A Performance Improvement tool has been developed that evaluates time provision of care. DNS or Designee will complete PI to weekly for four weeks, montfor a quarter and quarterly thereafter with results being forwarded to the PI committed for further review until 100% compliance is achieved.	ete ks, he ce nely ol thly		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING B. WING		UNSTRUCTION	COMPL 03/29/2	ETED	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER	{		2300 G	GREAT LAKES DRIVE		
REGENC	Y PLACE OF DYE	R		DYER,	IN46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F0282	REGULATORY OR	LSC IDENTIFYING INFORMATION)	F02	TAG	It is the practice of this facility		04/11/2011
			102	02	ensure the highest quality of c		04/11/2011
SS=D					is afforded our residents.		
					Consistent with this practice, t	he	
					following has been done:		
					The corrective action taken for		
					the residents found to have be		
					affected by the deficient practi	ice	
					was:		
					Res. E has been provided with		
					cloth briefs. Res. F's Ferrouse		
					Sulfate was restarted on 3/28/11 Peri care was provided to Res. I		
					Resident was interviewed and	.	
					stated she waited approximately	y 1	
					hour for staff to provide care.		
					Staff involved have been counse and educated on promptly	eled	
					responding to resident needs.		
					The corrective action taken for	r	
					those residents having the		
					potential to be affected by the		
					same deficient practice is:	,	
					Residents with an order for clot briefs have been observed to	h	
					ensure they are using cloth brie	fs.	
					Full facility review of all		
					Medication Records was		
					completed to ensure that there		
					were no other transcription errors. Interviewable residents		
					were asked if they had any issue		
					related to timeliness of care and		
					rounds on non-interviewable		
					residents were also made. No other issues were identified		
					other issues were identified		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G8L512 Facility ID:

000123

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING	COMPLETED 03/29/2011		
		133210	B. WING		03/29/2011
NAME OF F	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	
REGENO	Y PLACE OF DYE	₹	I	REAT LAKES DRIVE IN46311	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFTING INFORMATION)	IAG	through this process.	DATE
				through this process.	
				The measures put into place a systemic change made to ens the deficient practice does no recur is: Nursing staff was educated the DNS on using cloth bries when ordered and following the plan of care. Licensed shave been educated by the DNS on correctly transcribin orders to the resident medication administration record. Nursing staff has be educated by the DNS and E related to timely call light response and provision of cat the time of need. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of car An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician order.	by fs g taff ing een D are ce g nt t t ee

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218			A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/29/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	RESOLATORY OK	LOC BEATH THO BY ORWATION)	IAU	to the resident medication administration record. The DNS or Designee will comple PI tools weekly for four wee monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliant is achieved. A Performance Improvement tool has been developed that evaluates time provision of care. DNS or Designee will complete PI to weekly for four weeks, montfor a quarter and quarterly thereafter with results being forwarded to the PI committed for further review until 100% compliance is achieved.	ete ks, he ce nely ol thly		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S COMPL		
		155218	A. BUILDING B. WING			03/29/2011	
NAME OF F	PROVIDER OR SUPPLIER		D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
			2300 GREAT LAKES DRIVE DYER, IN46311				
	CY PLACE OF DYER				IN46311 •		71.F)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F0282	2. Resident #	F's record was	F02	82	It is the practice of this facility		04/11/2011
SS=D	reviewed on	3/28/11 at 11:50			ensure the highest quality of ca is afforded our residents.	are	
	a.m. Reside	nt #F's diagnoses			Consistent with this practice, t	he	
		t were not limited			following has been done:		
	· ·	act infection,			The corrective action taken for		
					the residents found to have been		
	congestive h				affected by the deficient practi	ce	
	anemia, and	arthritis.		was:			
					Res. E has been provided with		
	A) During the initial tour on				cloth briefs. Res. F's Ferrouse Sulfate was restarted on 3/28/11		
	3/28/11 at 10):15 a.m., with the			Peri care was provided to Res. F		
	SDC (Staff I	Development			Resident was interviewed and		
	Coordinator	present, Resident			stated she waited approximately hour for staff to provide care.	1	
	ĺ	rved sitting in her			Staff involved have been counse	led	
		n her room. The			and educated on promptly responding to resident needs.		
		dwelling catheter					
		<u> </u>			The corrective action taken for those residents having the	:	
	_	on the floor under			potential to be affected by the		
		air. The SDC			same deficient practice is:		
	applied glov	es and adjusted the			Residents with an order for clot briefs have been observed to	h	
	catheter tubi	ng so it was not			ensure they are using cloth brief	fs.	
	touching the	floor. The SDC			Full facility review of all		
	indicated the	e resident had a			Medication Records was completed to ensure that there		
	history of ur				were no other transcription		
	infections.	<i>J</i>			errors. Interviewable residents were asked if they had any issue		
	miconoms.				related to timeliness of care and		
	A 1- :	data d 2/16/11			rounds on non-interviewable residents were also made. No		
	A care plan,	dated 2/16/11,			other issues were identified		
					!		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155218	B. WIN	G	03/29/2011		
NAME OF	PROVIDER OR SUPPLIEI	- {		1	ADDRESS, CITY, STATE, ZIP CODE	-	
DECEN		B		1	REAT LAKES DRIVE IN46311		
REGENCY PLACE OF DYER				·	11140311		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
	indicated "U	Trinary elimination,			through this process.		
	altered patte	ern r/t (related to)					
	indwelling of	eatheter			The measures put into place ar	l l	
	notential ir	nfectionApproach.			systemic change made to ensu		
	1 ^	ainage bag below			the deficient practice does not recur is:		
		l. Do not let bag or					
		_			Nursing staff was educated	* I	
	tubing touch	i floor"			the DNS on using cloth brief when ordered and following	S	
					the plan of care. Licensed st	aff	
Resident #F was observed on				have been educated by the			
	3/28/11 at 1	2:50 p.m., sitting in			DNS on correctly transcribing	ıg	
		•			orders to the resident		
		t dining room. The			medication administration		
	resident's ca	theter tubing was			record. Nursing staff has be educated by the DNS and EI		
	observed un	der the wheelchair			related to timely call light	,	
	touching the	floor			response and provision of ca	re	
		7 11001.			at the time of need.		
	 Resident #F	was observed on			To ensure the deficient practic	e	
		2:52 p.m., with the			does not recur, the monitoring		
		1 ,			system established is:		
	_	furse Consultant			A.D. C Y	_	
	present, with	n the catheter			A Performance Improvemen tool has been developed that		
	tubing touch	ning the floor. The			will monitor residents for the	l l	
	1	Surse Consultant			proper use of cloth briefs		
	1 *				according to the plan of care	.	
	"	catheter tubing so			An additional Performance		
	it was not to	ouching the floor.			Improvement indicator has been established which		
					evaluates compliance with		
	B) Resident	t #F's physician's			transcribing physician order	s	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155218	B. WIN	B. WING 03/29/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311			
(X4) ID PREFIX TAG	orders recaping 3/11, indicated the stools for had been colorder was distinguished been obtained indicated the was still being an indicated the ferrous still being a stil	mg (milligram) ally) give 1 tab e a day. 2/28/11 cult stools s MAR administration ed 3/11, indicated r the occult blood lected and the scontinued after stool specimen had ed. The MAR e ferrous sulfate		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) to the resident medication administration record. The DNS or Designee will complete PI tools weekly for four week monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved. A Performance Improvement tool has been developed that evaluates tim provision of care. DNS or Designee will complete PI too weekly for four weeks, month for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliance is achieved.	DATE cte cs, de ce ely bl hly

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	to prevent recurr	relates to complaints				

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING B. WING		UNSTRUCTION	COMPL 03/29/2	ETED	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER	{		2300 G	GREAT LAKES DRIVE		
REGENC	Y PLACE OF DYE	R		DYER,	IN46311		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F0282	REGULATORY OR	LSC IDENTIFYING INFORMATION)	F02	TAG	It is the practice of this facility		04/11/2011
			102	02	ensure the highest quality of c		04/11/2011
SS=D					is afforded our residents.		
					Consistent with this practice, t	he	
					following has been done:		
					The corrective action taken for		
					the residents found to have be		
					affected by the deficient practi	ice	
					was:		
					Res. E has been provided with		
					cloth briefs. Res. F's Ferrouse		
					Sulfate was restarted on 3/28/11 Peri care was provided to Res. I		
					Resident was interviewed and	.	
					stated she waited approximately	y 1	
					hour for staff to provide care.		
					Staff involved have been counse and educated on promptly	eled	
					responding to resident needs.		
					The corrective action taken for	r	
					those residents having the		
					potential to be affected by the		
					same deficient practice is:	,	
					Residents with an order for clot briefs have been observed to	h	
					ensure they are using cloth brie	fs.	
					Full facility review of all		
					Medication Records was		
					completed to ensure that there		
					were no other transcription errors. Interviewable residents		
					were asked if they had any issue		
					related to timeliness of care and		
					rounds on non-interviewable		
					residents were also made. No other issues were identified		
					other issues were identified		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G8L512 Facility ID:

000123

If continuation sheet

Page 34 of 51

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	JNSTRUCTION	COMPLETED	
		155218	B. WING	03/29/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) through this process.	(X5) COMPLETION DATE
				The measures put into place a systemic change made to ensith deficient practice does no recur is: Nursing staff was educated the DNS on using cloth brie when ordered and following the plan of care. Licensed shave been educated by the DNS on correctly transcribin orders to the resident medication administration record. Nursing staff has been educated by the DNS and E related to timely call light response and provision of cat the time of need. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that will monitor residents for the proper use of cloth briefs according to the plan of car. An additional Performance Improvement indicator has been established which evaluates compliance with transcribing physician order.	by fs g taff ng een D are ce g nt t tee e.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		(x2) MULTIPLE CONSTRUCTION (x3) DATE SURVEY A. BUILDING (03/29/2011)					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				to the resident medication administration record. The DNS or Designee will comple PI tools weekly for four weemonthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliant is achieved. A Performance Improvement tool has been developed that evaluates timprovision of care. DNS or Designee will complete PI to weekly for four weeks, montfor a quarter and quarterly thereafter with results being forwarded to the PI commit for further review until 100% compliance is achieved.	ete ks, he ce ely ol hly		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155218	B. WING			03/29/2011	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	2300 GREAT LAKES DRIVE				
	Y PLACE OF DYE	₹		DYER,	IN46311		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	· · · · · · · · · · · · · · · · · · ·	4.	DATE
F0312		ation, interview, and	F03	12	It is the practice of this facility		04/11/2011
SS=D		e facility failed to ensure			ensure the highest quality of ca is afforded our residents.	are	
		ed necessary services to				ho	
		ersonal hygiene, related to			Consistent with this practice, t following has been done:	ile	
	leaving a residen	t lying in bowel			lonowing has been done.		
	movement for a	long period of time for 1			The corrective action taken for	,	
	of 10 residents w	ho required assistance			the residents found to have been		
	for toileting in a	sample of 11. (Resident			affected by the deficient practi	1	
	#E)				was:		
	Findings include	:			Peri care was provided to the Ro	es.	
	C				E. Resident was interviewed an		
	During an interv	iew on 03/28/11 at 11:42			stated she waited approximately	7 1	
	_	E indicated she had been			hour for staff to provide care. Staff involved have been counse		
	waiting an hour t				and educated on promptly	ieu	
	_	dicated CNA #1 came in			responding to resident needs.		
	_						
		r call light and she told			The corrective action taken for	r	
		been incontinent. She			those residents having the		
		1 turned off the call light			potential to be affected by the		
		was busy with another			same deficient practice is:		
		ther CNA had been			Interviewable residents were asl	ked	
	_	tesident. She indicated			if they had any issues related to		
	she would tell the	e Nurse. Resident #E			timeliness of care and rounds of	1	
	indicated LPN #3	3 came into the room and			non-interviewable residents wer also made. No other issues were	1	
	she informed the	LPN she had been			identified through this process.		
	incontinent of bo	wel movement and the			identified through this process.		
	LPN told her she	would tell the CNA					
	assigned to her.						
					The measures put into place ar	nd	l
	During an interv	iew on 03/28/11 at 11:45			systemic change made to ensu	re	
	_	licated the resident had			the deficient practice does not		
	,	been incontinent of bowel			recur is:		
		#3 indicated she had not					
	movement. LfN	mo marcarea sue nau not			Nursing staff has been educated	by	
					ļ		

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155218	B. WING		03/29/2011
			_	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L	l	0 GREAT LAKES DRIVE	
REGENO	CY PLACE OF DYE	R		ER, IN46311	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPROPR	IATE
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	informed the Res	sident's CNA because the		the DNS and ED related to tin	• 1
	CNA was on brea	ak. She indicated she		call light response and provisi	• • • • • • • • • • • • • • • • • • •
	would go tell the	CNA now.		care at the time of need. Clini Competencies were completed	• • • • • • • • • • • • • • • • • • •
				C.N.A.'s related to providing	WILII
	During an intervi	iew on 03/28/11 at 11:50		incontinence care.	
	_	dicated she was assigned			
	•	She indicated she had			
				To ensure the deficient pract	ice
		30 minute lunch break at		does not recur, the monitoring	• • • • • • • • • • • • • • • • • • •
		ndicated she was just		system established is:	
	informed the resi	ident needed some help.			
				A Performance Improveme	ent
	During an intervi	iew on 03/28/11 at 11:53		tool has been developed tha	• • • • • • • • • • • • • • • • • • •
	a.m., CNA #2 ind	dicate she had last		evaluates timely provision	
	-	esident around 8 a.m.		care. DNS or Designee will	l l
	when she picked			complete PI tool weekly for	I
	breakfast tray.	up the resident's		four weeks, monthly for a	
	orcakiasi ilay.			quarter and quarterly	
	D : 1	02/20/11		thereafter with results bein	σ
	_	vation on 03/28/11 at		forwarded to the PI commi	-
	· ·	#2 entered Resident #E's		for further review until 100	l l
	•	incontinence care to the		compliance is achieved.	
	resident. The Re	esident was observed to		Parameter of manage (can	
	have been incont	tinent of soft bowel			
	movement. The	bowel movement had			
	dried on the resid	dent's buttocks. Upon			
	interview of the	CNA #2 during the			
		indicated part of the			
		t had dried on the			
		CNA #2 then washed the			
		es to remove the dried			
		t. The resident's buttocks			
	was red and exco	oriated and there was a			
	superficial open	area on the posterior left			
	thigh was approx	simately the size of a			
	- ^^	-			

000123

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY ETED
		155218	B. WIN			03/29/2	011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	REAT LAKES DRIVE		
	CY PLACE OF DYE			DYER, IN46311			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAU	dime, round in sh	· · · · · · · · · · · · · · · · · · ·		IAU	,		DATE
	l '	open area was pink.					
		iew at the time of the					
	~	A #2 indicated the skin					
	· ·	oriated on the Resident's					
		dicated the area on the					
	left posterior this						
	ien posterior ung	sii was openea.					
	 During an intervi	iew on 03/28/11 after the					
During an interview on 03/28/11 after the incontinence care had been completed, the							
Resident indicated she was uncomfortable							
laying in the bowel movement.							
		of movement.					
	During an intervi	iew on 03/28/11 at 12:05					
	_	licated the Resident had					
	* ·	ing incontinent of bowel					
		d 11:20 a.m. or 11:30					
	a.m. She indicat	ed the other CNA's on					
	the unit were all	busy and she was on the					
	phone with a fan	nily member so she could					
	not take care of r	resident when she					
	requested help.						
	_						
	During an intervi	iew on 03/28/11 at 12:15					
	p.m., CNA #1 in	dicated the resident had					
	told her she had	been incontinent of bowel					
	movement. She i	ndicated she was getting					
	ready to give and	other resident a shower,					
	but answered Re	sident #E's call light. She					
	indicated she had	I turned the call light off					
	and left the room	and told the nurse the					
	resident had beer	n incontinent and needed					
	help. She indica	ted she did not remember					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BI		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/29/2011	
	PROVIDER OR SUPPLIER		2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE IN46311	.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	what time she an light.	swered the resident's call					
	diagnoses includ to, hypertension The Annual Min Assessment, data resident was cog score of 15, required for toileting, bed hygiene, and was of bowel (two or A care plan, data resident was at resident was	ed 01/18/11, indicated the nitively intact with a ired extensive assistance mobility, and personal is frequently incontinent more episodes). d 03/24/11, indicated the isk for impaired skin oproaches indicated, "1. & (and) dry" esource, titled, "Indiana t of Health Division of Nurse Aide Training 07/98, page 60, ncontinencea. to meet incontinent resident the spond to call light Check resident often for ing. Provide frequent					

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE S COMPL 03/29/2	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX (E	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	FIX (E	EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIAT	TE .	COMPLETION

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155218	A. BUII B. WIN			03/29/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER		2300 GREAT LAKES DRIVE				
	CY PLACE OF DYEF		DYER, IN46311		IN46311		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
F0315	Based on ob	servation, record	F03	15	It is the practice of this facility		
SS=D	review, and	interview, the			ensure the highest quality of call is afforded our residents.	are	
	facility failed	d to ensure a			Consistent with this practice, t	he	
	_	h an indwelling			following has been done:		
	catheter had	the catheter tubing			The corrective action taken for	r	
	positioned to	prevent infection			the residents found to have been		
	•	sidents reviewed			affected by the deficient practi	ce	
		rs in a sample of					
	11. (Residen	•			Res. F's Foley has been secured position and is off the ground.	ın	
	Findings Inc	,			The corrective action taken for those residents having the potential to be affected by the same deficient practice is:	г	
	_):15 a.m., with the			Residents with foley cathete		
		Development			were observed to ensure that	;	
	`	present, Resident			they were receiving appropriate treatment and		
	ĺ	*			services to prevent urinary		
		rved sitting in her			tract infections. Appropriate	e	
		n her room. The			interventions were implemented to ensure tubin	g	
		dwelling catheter			was secure.		
		on the floor under			The measures put into place a		
	the wheelcha	air. The SDC			systemic change made to ensu		
	applied glov	es and adjusted the			the deficient practice does not		
	catheter tubi	ng so it was not			recur is:		
	touching the	floor. The SDC			Nursing staff was educated	by	
	indicated the	e resident had a			the DNS on techniques for securing foley tubing.		
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	38L512	Facility	ID: 000123 If continuation s	heet Page 42 of 51	

NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER IN 16044	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	
NAME OF PROVIDER OR SUPPLIER 2300 GREAT LAKES DRIVE		
REGENCY PLACE OF DYER DYER, IN46311		
DYER, INAGESTI DYER	REGENCY (X4) ID PREFIX TAG	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING			COMPL 03/29/2	ETED	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER			1	REAT LAKES DRIVE		
REGENO	CY PLACE OF DYE	₹	DYER, IN46311				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
TAG		was observed on	-	TAG	DEFICIENCE		DATE
		2:50 p.m., sitting in					
		dining room. The					
	resident's car	theter tubing was					
	observed un	der the wheelchair					
	touching the	floor.					
	Resident #F	was observed on					
3/28/11 at 12:52 p.m., with the							
	Corporate Nurse Consultant						
	-	the catheter					
	•						
	_	ing the floor. The					
	•	urse Consultant					
	adjusted the	catheter tubing so					
	it was not to	uching the floor.					
	This deficiency v	was cited on 12/28/10 and					
	03/03/11. The Fa	acility failed to					
	•	remic plan of correction					
	to prevent recurr	ence.					
	This Federal tag	relates to complaints					
	IN00083771 and	•					
	3.1-41(a)(1)						
	3.1-41(a)(2)						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP 03/29/2	LETED
	PROVIDER OR SUPPLIER		STREET A 2300 G	ADDRESS, CITY, STATE, ZIP COD REAT LAKES DRIVE IN46311	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		NSTRUCTION	COMPL	ETED
		155218	B. WING			03/29/2	U11
	PROVIDER OR SUPPLIER		2	300 GF	DDRESS, CITY, STATE, ZIP CODE REAT LAKES DRIVE N46311		
	T FLACE OF DIER	`		, i EK, i	1140311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
			+		It is the practice of this facility	to	
F0315 SS=D			F0315		It is the practice of this facility ensure the highest quality of ca is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practic was: Res. F's Foley has been secured position and is off the ground. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Residents with foley catheter were observed to ensure that they were receiving appropriate treatment and services to prevent urinary tract infections. Appropriate interventions were implemented to ensure tubing was secure. The measures put into place an systemic change made to ensure the deficient practice does not recur is:	he he ce in ce g	04/11/2011
					Nursing staff was educated to the DNS on techniques for securing foley tubing.	, j	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G8L512

Facility ID:

000123

If continuation sheet

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l	IT OF DEFICIENCIES OF CORRECTION	TION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED 02/20/2044		
		155218	B. WING		03/29/2011		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE				
	CY PLACE OF DYER		DYER,	IN46311	_		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that will monitor residents with foley catheters to ensure that the tubing is correctly secure. The DNS or Designee will complete PI tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committed for further review until 100% compliance is achieved.	e t d.		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
1111212111	or confidence	155218	A. BUILDING B. WING			03/29/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			l	GREAT LAKES DRIVE	
REGENO	CY PLACE OF DYEF	₹	DYER, IN46311			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCE OF THE PROFICE OF THE APPROFIDENCY)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG			F04		It is the practice of this facility	DATE
F0441		ation and interview, and	F04	41	ensure the highest quality of c	
SS=D	•	cility failed to ensure a			is afforded our residents.	arc
	•	ment to help prevent the			Consistent with this practice, t	he.
	-	transmission of disease			following has been done:	
		ated to hand washing and			3 5 2022	
		during and after contact			The corrective action taken for	r
		r 2 of 4 observations of			the residents found to have be	en
		its in a sample of 11.			affected by the deficient practi	ice
	*	d #F, CNA #2 and Staff			was:	
	Development Co	ordinator).				
					There has been no adverse affect noted to Res. E related to the no	I
	Findings include:				provision of incontinence care of	•
					to Res. F related to the failure to	I
	· -	servation on 03/28/11 at			wash hands prior to exiting the	
	· ·	#2 entered Resident #E's			room.	
	•	incontinence care to the				
		A applied gloves and			The corrective action taken for	r
		dent's brief. The Resident			those residents having the potential to be affected by the	
	was observed to l	have been incontinent of			same deficient practice is:	
	soft bowel mover	ment. The CNA used			same deficient practice is.	
	•	to wash the resident skin			Resident rounds were complete	d to
		rement. The resident's			ensure that staff were utilizing	
	buttocks was red	and excoriated and there			gloves appropriately, there were	I
	was a superficial	open area on the			no further incidence of catheter tubing touching the floor, and	
	posterior left thig	th. The CNA then applied			handwashing practices were	
	a barrier cream to	the resident's buttocks			completed per facility policy.	
	and upper posteri	or thighs without			Immediate education with the s	taff
	changing gloves	and washing hands. The			was provided as indicated.	
	CNA then change	ed her gloves and asked			The measures of the col	
	the Resident to tu	irn onto her back. The			The measures put into place an	l l
	CNA then provid	ed peri-care and applied			systemic change made to ensu the deficient practice does not	l l
	barrier cream to t	the resident's groin			recur is:	
		gloves and washing her			10001 15.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155218		A. BUILDING		COMPLETED 03/29/2011			
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
TAG	hands. During an intervery p.m., CNA #2 incompanies washed before an indicated she washed during care. During an intervery p.m., RN #4 indicated she washed before the peri-anal and should be washed.	iew on 03/28/11 at 1:45 dicated hands were to be and after care. She is suppose to wash her if they needed it. iew on 03/28/11 at 1:50 cated hand washing refore and after care. She is unsure of the facility's cated the gloves need to be going to different parts area. She indicated hands dispersive the dispersive tream.	TAG	Facility staff was educated by DNS and ED related to infect control practices to include he washing technique and the pruse of gloves. To ensure the deficient practices not recur, the monitoring system established is: A Performance Improvem tool has been developed the evaluates hand washing technique and glove use. If or Designee will complete tool weekly for four weeks monthly for a quarter and quarterly thereafter with results being forwarded to PI committee for further review until 100% compliatis achieved.	y the cion and roper tice ng PI , the the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/29/2011		
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG F0441 SS=D	2. During the 3/28/11 at 10 SDC (Staff I Coordinator) #F was observable wheelchair is SDC indicated a history of infections. To indwelling continuous and a catheter tubic touching the removed her room without hands. During an infat 2:40 p.m., she should her	ne initial tour on 0:15 a.m., with the Development) present, Resident erved sitting in her in her room. The ed Resident #F had urinary tract The resident's eatheter tubing was under the The SDC applied	F04	TAG	It is the practice of this facility ensure the highest quality of cris afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practic was: There has been no adverse affect noted to Res. E related to the noted to Res. E related to the failure to wash hands prior to exiting the room. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Resident rounds were completed ensure that staff were utilizing gloves appropriately, there were no further incidence of catheter tubing touching the floor, and handwashing practices were completed per facility policy. Immediate education with the staff was provided as indicated. The measures put into place an systemic change made to ensure the deficient practice does not recur is:	to are he ren ce de toted ren	DATE 04/11/2011

000123

	OF CORRECTION	IDENTIFICATION NUMBER: 155218	A. BUILDING	CONSTRUCTION	COMPLETED 03/29/2011		
NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF DYER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			B. WING O3/29/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DRIVE DYER, IN46311 ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)				
TAG	A facility policy, "Hand Hygiene/I from the Administindicated, "Har performed:After fluids, secretions contaminated iter are worn; Between on the same resid with body fluids cross-contaminate sitesAfter hand utensilsIntermit removed, between	dated 10/09, titled, Hand washing", received strator as current, and hygiene is to be er touching blood, body excretions and ans, whether or not gloves en tasks and procedures elent when contaminated to prevent ion of different body ling soiled equipment or ttently after gloves are are resident contacts"	TAG	Facility staff was educated by t DNS and ED related to infectio control practices to include har washing technique and the projuse of gloves. To ensure the deficient practic does not recur, the monitoring system established is: A Performance Improvement tool has been developed that evaluates hand washing technique and glove use. DN or Designee will complete Pl tool weekly for four weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review until 100% compliant is achieved.	he n dd per ee g		